

FACING THE FUTURE TOGETHER:

Report of the Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa



A UNAIDS Initiative
**The Global Coalition
on Women and AIDS**



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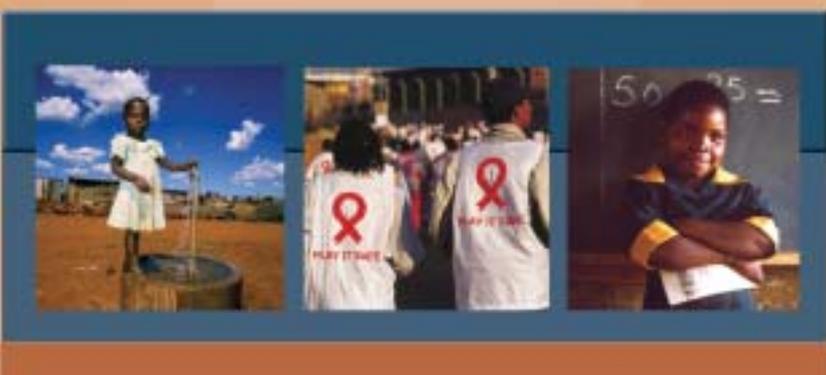
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ABBREVIATIONS

ARV	Antiretroviral
AZT	Zidovudine
ABC	Abstinence, Be faithful, Condom use
CBOs	Community Based Organizations
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
HAART	Highly Active Anti-Retroviral Therapy
IRI	Interactive Radio Initiative
LAC	Namibia's Legal Assistance Centre
MFC	Men for Change
MSF	Medicines sans Frontiers
MTCT	Mother-to-child transmission
NGOs	Non-governmental Organizations
NVP	Nevirapine
NZP+	National Zambian People's Positive Association
PEP	Post-exposure HIV Prophylaxis
PMTCT	Prevention of mother-to-child transmission
SADC	Southern African Development Community
SWAPOL	Swaziland Positive Living for Life Organization
U.N.	United Nations
U.S.	United States of America
VCT	Voluntary Counselling and Testing
WAR	Women Against Rape
WHO	World Health Organization
WLSA	Women and Law in Southern Africa
ICW	International Community of Women living with HIV/AIDS

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FOREWORD

KOFI ANNAN

UNIDPI Photo by Sergey Bermentiev



Kofi Annan, Secretary-General of the United Nations.

southern Africa to keep families together and care for the sick cannot be ignored. This report documents their realities.

The Task Force spoke with many people, from policy-makers to schoolgirls. It has put on the record what many southern Africans have had difficulty admitting for far too long: that despite the existence of some excellent laws and sound policies, many communities are failing to protect women and girls from HIV infection and from the social consequences of AIDS. The report stresses that although women’s resilience and strength are well known in Africa, the “coping skills” they possess are not an infinite resource. More attention must be paid, more resources allocated, to linking HIV prevention activities with girls’ education and the prevention of gender-based violence. This report outlines the changes required of Governments in enacting legislation and developing policy and programme guidance — areas in which the United Nations has significant expertise. Yet there is also a need for

The establishment in 2003 of the Task Force on Women, Girls and HIV/AIDS in Southern Africa brought together men and women from diverse walks of life who, thanks to their tireless efforts in the fight against HIV/AIDS, had one thing in common: they represented a group of people who could not be ignored.

Similarly, the efforts of women and girls across

“THIS REPORT STANDS AS A TESTIMONY TO THE HOPES AND FEARS OF A GENERATION OF WOMEN AND GIRLS. IF WE IGNORE ITS MESSAGES, WE WILL HAVE BETRAYED THEM. IF WE LISTEN, WE WILL HAVE A SOLID BLUEPRINT WITH WHICH TO GUIDE OUR ACTIONS”

KOFI ANNAN, SECRETARY-GENERAL OF THE UNITED NATIONS

a real shift in how women are perceived and treated. Without normative social change, we are warned, laws and policies will have limited impact.

This report also features the words of Rumbidzai Mushangi, aged 15. “I don’t want to die before I turn twenty-five,” she says. “I refuse to sit down and watch my generation fall to pieces. I am going to make a difference. Will you?”

The work of the Task Force responds directly to Rumbidzai’s challenge. It provides powerful arguments to guide the work of development agencies. One of its central tenets is that leadership comes not only from those who hold powerful positions. Leadership comes from partners who demonstrate respect by using a condom. Leadership comes from fathers, sons and uncles who support and affirm women’s right to own land. Leadership comes from teachers who nurture the dreams and aspirations of girls, and from doctors and nurses who listen and provide care without judgement.

This report stands as a testimony to the hopes and fears of a generation of women and girls. If we ignore its messages, we will have betrayed them. If we listen, we will have a solid blueprint with which to guide our actions — a sound plan with which to support Rumbidzai and her peers.

A CALL TO LEADERSHIP

PETER PIOT



UNAIDS

UNAIDS Executive Director Peter Piot

might succumb to despair. In other words, leaders.

The HIV/AIDS crisis has shown us that leaders come from all walks of life. As the pandemic has ravaged Southern Africa, women – many of them poor and many of them HIV-positive – have played a key leadership role at the community level. Yet their contribution has rarely been recognized or supported by those with decision-making power. And although women and girls account for the majority of new HIV infections in sub-Saharan Africa, this has not been reflected in the policies or the material resources committed to fight the disease. It is high time for that to change, and for women themselves to be given a greater role in shaping the programmes and strategies we will need if we are to stem the tide of the pandemic.

Declarations of intent are not lacking. Ever since the Convention on the Elimination of All Forms of Discrimination Against Women was written a quarter of a century ago, Africans have listened to lofty declarations from the U.N. General Assembly, sonorous pronouncements from Heads of State and regional organisations such as the Southern African Development Community (SADC), and landmark agreements at international conferences. But not enough of these global and regional commitments have been acted upon.

One reason often cited is the sheer magnitude of the challenge we face. Confronted with a phenomenon as overwhelming as HIV/AIDS in Africa, not to mention the deep-rooted gender inequality that is a principal force driving the spread of the disease, it's easy to be paralysed. Even organisations that have made gender inequality the explicit focus of their work often find it easier to deal

with the symptoms rather than the underlying causes of the pandemic. But the scale and complexity of the issue cannot be an excuse for inaction. Admittedly, it will take many decades to overcome Southern Africa's legacy of social and economic inequality. But in the meantime there is urgent work to be done – work that responds to the short-term emergency while at the same time attacking the deeper underlying roots of the problem. For that work to succeed, we must find ways of channelling the resources that are available into the hands of those who are best equipped to lead the fight.

Fortunately we have learned a great deal in the two decades since HIV/AIDS made its appearance. The basic structures are in place to guide national responses to HIV/AIDS and to unleash the leadership potential of women in combating the disease. Governments have signed on to the main international treaties that affirm the rights of women and children, discriminatory national laws have been scrapped, policymaking processes have been streamlined, and government officials have elevated women's rights and the fight against HIV/AIDS to the forefront of public debate and discussion.

At the national level, we know what works. We know that if national health care and education systems are made more flexible, if they respond less to the needs of the bureaucracy and more to the needs of the community, women and girls will enjoy greater access to their benefits. And even though we still have a long way to go, we know, too, that women's rights to economic independence – especially in the crucial area of property and inheritance rights – can be enhanced by new laws, more flexible justice systems, and more intensive training for grassroots NGOs.

At the same time, we know what *doesn't* work. Part of the challenge we face is that gender inequality is pervasive – it cuts across all issues. It is everyone's problem, and for that very reason it can often appear to be no one's particular responsibility. We need to understand that "women's issues" are not some discrete cluster of problems and programmes that can be assigned – or perhaps *relegated* is a better word – to "special" government agencies. They must be everywhere. It is no good making "women's issues" the preserve of one part of government, and HIV/AIDS the preserve of another. If we are to defeat the epidemic, we will need to overcome these artificial distinctions.

Above all, we will need to bridge the gap that prevents resources from reaching the levels of leadership where they can be used most effectively. Again, we have learned a great deal about what works. We know that community-based education can challenge the social norms and values that assign an inferior social status to women and girls and condone violence and abuse against them. We know that life-skills and other school-based programmes can increase girls' self-confidence and self-esteem. And we know that women and

girls can gain greater control over their own lives if they are given access to credit and business and marketing skills.

The United Nations has an absolutely vital role to play here. The UN system can provide information and technical support. It can set standards for the treatment of women and girls and monitor their enforcement. Above all it can broker partnerships between governments, civil society, donors and international agencies to ensure that resources are channelled where they are most needed, and where the investment will be most richly repaid – to the women and girls in the cities, towns and villages of Southern Africa. This means support for small women’s organisations, for associations of people living with HIV/AIDS, and for community-based organisations (CBOs) working to alleviate poverty. It is these grassroots groups that are best placed to identify the real needs of women on the ground (especially among marginalised populations such as refugees, domestic workers and other migrants) and to nurture a new generation of leaders.

For now, while many of these organisations depend on the work of women as grassroots volunteers, men remain more visible in leadership positions. But this will change as women are given the support they need to take on a greater role in shaping programmes and policies. Inevitably there will be frictions along the way. An honest appraisal of the unequal power relations between men and women will provoke discomfort, even active resistance. But men and boys will benefit from the process just as much as women and girls. Gender roles – which equate masculinity with sexual prowess, multiple sex partners, physical aggression and dominance over women, a readiness to engage in high-risk behaviour, and an unwillingness to access health services or seek emotional support – impose a terrible burden on men. If they can be encouraged to behave in ways that reduce their own risk of HIV transmission, men and boys themselves will emerge stronger, no longer stigmatised as drivers of the pandemic but enlisted as partners – as fellow-leaders – in finding the solution.

EXECUTIVE SUMMARY: A CALL TO ACTION

CAROL BELLAMY

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UNICEF Executive Director Carol Bellamy

As the HIV/AIDS pandemic devastates families and communities across Southern Africa, the burden is falling most brutally on women and young girls. If we can stop the spread of HIV among women and girls in the sub-region, we have a fighting chance of turning the pandemic around. But because of what we now know about the ways in which the disease has spread, defeating HIV/AIDS will mean

attacking a more deep-rooted and in many ways a tougher adversary – namely the inequality between men and women in the sub-region. Our desire for equality, in other words, must be every bit as powerful and passionate as our desire to halt the spread of the disease.

Pervasive gender inequality, and the violations of the rights of women that accompany it, is one of the most important forces propelling the spread of HIV amongst women. Inequality is apparent in laws that treat women as second-class citizens, in social norms and customs that deprive them of knowledge about their own bodies and strip them of the power to make independent decisions, in endemic (and widely sanctioned) patterns of violence and abuse, in inadequate access to health care, in the disproportionate burden women bear in caring for the sick and in holding ravaged families together. If we fail to transform the status of women, the catastrophe of HIV/AIDS will deepen, and the ability of women to cope, already critically stressed, may totally disintegrate.

The evidence for these assertions is compelling, yet for the most part this is not where we have directed our resources. Until now, most efforts to halt HIV/AIDS have been what the social scientists would call “gender-neutral.” In other words, the messages designed to change behaviour and reduce the risks of HIV transmission have been aimed generically at the whole population, male and female alike. These messages have failed to take into account the specific needs of women and girls, and the often

difficult reality of their daily lives. The result is that we have targeted the symptoms of the pandemic rather than the underlying causes, and the consequences of this failure have been catastrophic.

The Realities of HIV/AIDS in Southern Africa

While HIV prevalence rates are high among all sexually active women in the sub-region, it is girls and young women who have been worst affected. Indeed, the great majority of young people aged 15-24 living with HIV/AIDS in Southern Africa – as many as 80 percent in Zambia and Zimbabwe – are female.

For some time now, it has been clear that women in Africa are buckling under the strain – besieged on one hand by high infection rates and on the other by the increased demands they face as caregivers and breadwinners. At the Barcelona International AIDS Conference in July 2002, Stephen Lewis, the United Nations Secretary General’s Special Envoy on HIV/AIDS in Africa, reported:

The toll on women and girls is beyond imagining; it presents Africa and the world with a practical and moral challenge, which places gender at the center of the human condition... For the African continent, it means economic and social survival. For the women and girls of Africa, it’s a matter of life and death.

Every bit as alarming as the raw numbers is new data showing that many young women are being infected almost as soon as they begin having sex. As this report shows, the *character* of that sexual activity is the most eloquent proof possible of how severely the burden of inequality falls on young girls. Many women and girls simply find it impossible to engage in sex as equal or even willing partners. Inequality, often expressed in the form of violence, strips them of the ability to turn down unwanted sex or negotiate safer sex. Poverty and HIV infection are deeply intertwined. As the burden of caring for the sick, the dying and the orphaned forces millions of African women deeper into poverty and batters their energy and self-esteem, so it increases the pressure to resort to high-risk “transactional” sex – sex in exchange for money or goods – or sex with older “sugar daddies” who offer the illusion of material security. And as more and more women and girls take to the streets as their only means of survival, the need to confront gender inequality becomes inescapable.

New data, new strategies

For several months in 2003, the Secretary General’s Task Force on Women, Girls and HIV/AIDS in Southern Africa engaged in

intensive on-the-ground consultations in the nine countries in the sub-region with the highest HIV prevalence rates – Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The report of the Task Force not only presents valuable empirical data on the scale and character of the pandemic; more importantly, it has identified six areas in which intervention is most urgently needed, and in which new strategies have a realistic prospect of success in halting the spread of HIV/AIDS, while at the same time attacking the gender inequality that has driven the pandemic.

1. Prevention – we must protect girls from the risk of HIV infection by older men

One of the most critical factors driving the pandemic is the prevalence of sexual relationships between young girls and adult males five or ten years their senior. These men are more likely to be infected than younger men and boys, and relationships with them are inherently more unequal and more conducive to abuse, exploitation and violence. Until now, the standard slogan for preventing HIV transmission has been “Abstinence – Be Faithful – Condom Use” – the so-called “ABC” of prevention. This approach is not inherently wrong. But by itself it is insufficient, since unequal power relations, often reinforced by coercion, abuse and violence, prevent women and girls from making informed choices about their own sexuality and survival.

2. Education – we must take active measures to keep girls in school

Southern Africa has been a regional leader in achieving girls’ enrolment in school, with rates as high as – and sometimes higher than – those for boys. Now the challenge is to keep them there. Though more hard data is still needed, anecdotal evidence suggests that girls are being pulled out of school in growing numbers – to care for the sick, when they are orphaned, or as a result of the economic impact of HIV/AIDS on their families.

3. Violence – we must protect women and girls from the risk of exposure to HIV infection as a result of violence

Women and girls who have been raped or sexually assaulted face an increased risk of infection. In such cases, the provision of post exposure prophylaxis can avert infection. In others, the threat is long-term and indirect – research shows that sexual violence substantially increases the likelihood that a girl or woman will engage in high-risk sexual behaviour later in life.

4. Property and inheritance – we must protect the right of women and girls to own and inherit land

In many Southern African countries, both civil and customary law deny women the right to own or inherit land or property. Without this right, the death of a husband, partner or parent can mean destitution, and this in turn can leave women prey to sexual exploitation and violence. A few determined organisations are working to provide legal education and advice to women and girls fighting to keep or recover property that has been taken from them, but much more needs to be done.

5. Women and girls as care-givers – we must have a volunteer charter

Communities have long relied on the resilience of women as an inexhaustible safety net for the sick, the dying or the orphaned. But this is no longer sustainable. Those who perform this physically and mentally gruelling work deserve not only respect, but standardised protections.

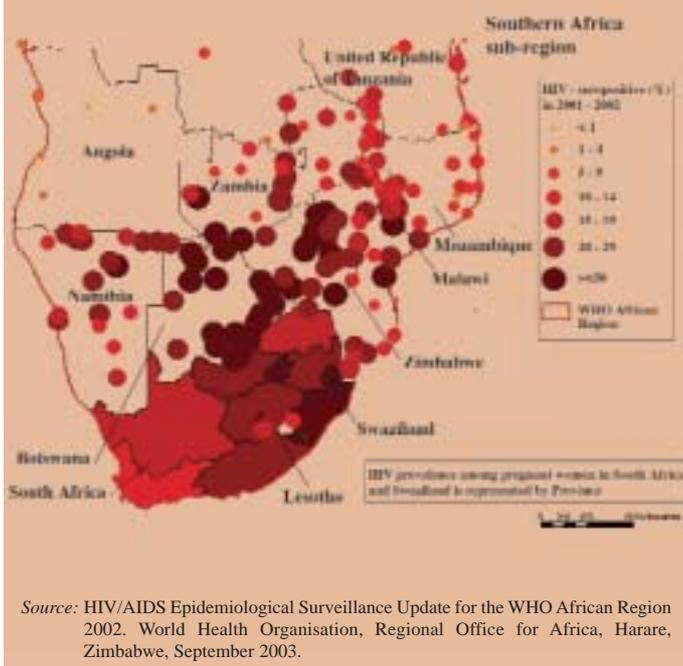
6. We must remove the barriers that prevent women from gaining access to medical care and treatment

Since they have more routine contact with public health systems (notably via ante-natal care), women may find it easier than men to obtain anti-retroviral treatment in some areas. However, the fear of stigma, violence and discrimination once a partner discovers a woman’s HIV status is a serious impediment to necessary treatment.

1. INTRODUCTION: FACING REALITIES

Southern Africa is the epicenter of the global HIV/AIDS pandemic. After growing steadily for two decades, the prevalence rates appear at last to have stabilised – but at shockingly high levels of prevalence. By 2002, more than 20 percent of pregnant women tested were HIV-positive, with several countries in the sub-region reporting a rate of infection in antenatal care clinics of more than 25 percent. (see figure 1)

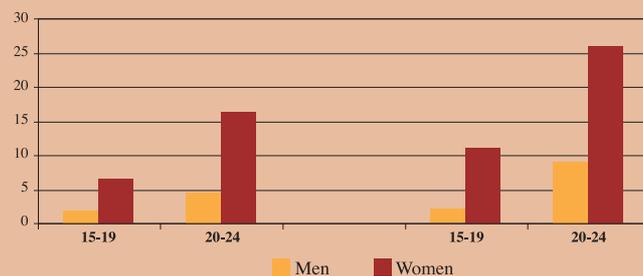
Figure 1: HIV prevalence among women attending antenatal care clinics in southern Africa. Data reported by clinic site or city, 2001-2002



High levels of HIV among women throughout southern African

Sub-Saharan Africa is also the only region in the world in which HIV infection rates are higher among women than men. For every ten men with the HIV virus, thirteen women are infected. The impact on young women and girls aged 15-24 – those who have only recently become sexually active – is even more dramatic. They are *two and a half times* more likely to be infected than males in the same age group. The gap is larger still in Southern Africa, where in Zambia and Zimbabwe girls and young women make up close to a staggering *eighty percent* of all young people aged 15-24 who are living with HIV/AIDS. (see figure 2)

Figure 2: HIV prevalence among young men and women aged 15-24 years in national population-based surveys, Zambia and Zimbabwe, 2001-2002.



Source: HIV/AIDS Epidemiological Surveillance Update for the WHO African Region 2002. World Health Organisation, Regional Office for Africa, Harare, Zimbabwe, September 2003.

What are the reasons for this enormous disparity? Why are women and young girls bearing the brunt of the pandemic in Southern Africa? The answers lie in poverty, violence and gender inequality.

Social Norms and Values: Women as Second-Class Citizens

To the casual observer, it might appear that women and girls in Southern Africa have made real strides toward social equality in recent years. After all, equal rights are now enshrined in a variety of international and regional treaties as well as in national constitutions and women are more deeply involved than ever before in the political affairs of many countries. Yet formidable gaps remain. In many Southern African countries, ingrained social and cultural norms relegate women to a lower social and economic status. Often treated as legal minors, barred from owning or inheriting property, unable to make independent financial decisions, women are vulnerable to poverty, exploitation, violence – and ultimately to HIV infection, which lies at the end of this long causal chain of injustice.

Poverty and Inequality

The nations of Southern Africa remain among the most economically unequal in the world. With much of the sub-region mired in poverty, communities have found their ability to withstand the onslaught of HIV/AIDS severely compromised, with the burden falling disproportionately on women and girls. More households here are headed by women than in any other part of sub-Saharan Africa. Altogether, more than thirty-four percent of households with children are female-headed – almost double the rate in West and Central Africa. The proportions are especially high in Botswana (52 percent), Namibia (47 percent) and South Africa (46 percent). Under intense pressure to feed and care for their families,

women and girls often fall prey to exploitation and abuse, feeling they have no choice but to exchange sex for food and other basic commodities. The younger the woman, the greater her vulnerability. As a result, women and girls find themselves locked in a vicious cycle – forced by poverty into unprotected sex, infected by HIV, and then driven deeper into poverty by disease, inability to do productive work, and the burden of caring for others who are sick.

Women Without Men, Men Without Women: Migration

Southern Africa, with its relatively well-developed transportation infrastructure, is also set apart from the rest of sub-Saharan Africa by its economic reliance on large-scale flows of migrant labour. For decades, millions of Southern African men have been forced to find work in distant mines and factories, where they live for long periods in squalid single-sex hostels. Similar numbers of women also find themselves far from home, the majority of them compelled to search for poorly paid work as domestic servants.

These migration patterns have had devastating results, further eroding community structures, undermining the cohesion of families, aggravating social alienation, and encouraging transient and risky sexual relations. Separated from their partners and families for prolonged periods, migrant workers are cut off from the social support networks that might act as a deterrent to unsafe sexual behaviour. When their husbands return home on visits, women are likely to face an elevated risk of HIV infection, made worse by their reluctance to confront the family breadwinner on the sensitive issue of using a condom. Conversely, the pressures of



Grey Strubbs

Large flows of migrant labour separates partners and their families for prolonged periods.

isolation and poverty on the wives of migrant workers mean that growing numbers of women are becoming infected with HIV before their husbands. At the same time, female migrant workers who have travelled far from home, or crossed national borders, in search of factory jobs, farm labour or domestic employment, often find themselves the victims of abuse and exploitation.

Where Do We Go From Here?

Fragmented and marginalised groups – refugees, migrant labourers, the poorest of the poor – are at the heart of the HIV/AIDS pandemic. Yet HIV prevention programmes have rarely succeeded in reaching these groups effectively. If we are to confront the reality of the disease head-on, it will mean finding new ways of addressing the particular needs of these women and girls and their families. Our challenge is to devise programmes that reach them directly and allow them to become the central actors in determining their own future.

2. KEEPING GIRLS IN SCHOOL, KEEPING SCHOOLS SAFE

One of the first imperatives in turning around the HIV/AIDS pandemic is to make sure that girls receive the best education possible. The mere fact of being in school can help protect girls from infection, since girls in school show lower rates of sexual activity. But schools also have to provide a safe space in which to learn, free of harassment and abuse, and they must offer a curriculum that teaches boys and girls alike how to make informed decisions about their lives, how to communicate effectively with each other, and how to build assertiveness and self-esteem.

There is no question that education helps girls and women to achieve greater control over their lives, giving them the skills they need to protect their own health and well-being and make a tangible contribution to the societies in which they live. Recent studies in Zambia and elsewhere show that better educated people have lower rates of HIV infection. Higher levels of education are directly related to increased awareness and knowledge of HIV/AIDS, greater knowledge of testing facilities, higher rates of condom use, and better communication between partners about HIV prevention.

Keeping Girls in School

In contrast to other parts of the continent, Southern Africa has relatively high school enrolment rates and in some countries has managed to achieve parity in the numbers of girls and boys attending both primary and secondary schools. In Botswana, Lesotho, Namibia and South Africa, in fact, secondary school enrolment among girls is higher than for boys. (see Figure 3)

Figure 3: Secondary school enrolment

The number of children enrolled in secondary school, regardless of age, divided by the population of the age group that officially corresponds to secondary school



Source: UNICEF State of the World's Children 2004.

"THERE WAS THIS GIRL IN CLASS WHOM SOME BOYS WERE TOUCHING AND SHE KEPT ON HITTING THEM WITH BOOKS AND TELLING THEM TO STOP AND THEN ALL OF A SUDDEN SHE STARTED CRYING, AS IF SOMETHING, PART OF HER HAD BEEN TAKEN AWAY."

ADOLESCENT GIRL, BOTSWANA¹

Yet these statistics do not tell the whole story. Enrolment is not the same thing as completion, and all over the world more girls than boys drop out of secondary school. There are many reasons for this, including pregnancy, early marriage, domestic duties and sexual violence. Now, new studies from Botswana, Lesotho and Zambia suggest that HIV/AIDS is leading to increased drop-out rates, as girls are pulled out of school to care for their sick, or when their parents die, or because of the economic impact of the epidemic on their families. In Lesotho, for example, the most recent statistics show that HIV/AIDS and poverty are responsible for a 25 percent drop in female enrolment over the last decade, with orphans dropping out at an even more dramatic rate.

We know that school enrolment and poverty are directly related. Wherever formal or informal fees are introduced, fewer children stay in school. Girls may respond to this kind of economic pressure by dropping out, or they may end up in relationships with older men who help pay for their education. The abolition of school fees is therefore critical to maintaining enrolment levels, and Zambia recently took this bold step. However, crippling foreign debt and the decline of bilateral funding for education make it hard for other countries to follow suit.

Creating a Safe Space for Learning

Unfortunately, schools often fail to provide the safe space that is necessary for learning. Studies from several Southern African countries, including South Africa, Swaziland and Zimbabwe, indicate that girls experience high levels of sexual violence in school. Adolescent girls cite sexual harassment, including unwanted touching and inappropriate sexual comments, as their most pressing concern. Male teachers as well as students are responsible for this abuse. Girls in Zambia and Zimbabwe, for example, report being ignored in class, punished, insulted, or given low marks if they refuse sexual advances from teachers. And Zambian girls in their late teens describe teachers abusing their authority by offering "leakages" from exam papers in exchange for "love."

¹ UNICEF, Finding our Voices, Gendered & Sexual Identities and HIV/AIDS in Education, Nairobi, 2003

Clearly this type of harassment has a negative impact on girls' self-esteem and ability to learn. Worse, it may put them at greater risk of contracting HIV, given the high rates of infection among teachers in the sub-region. Sexual abuse and harassment are rarely punished, and girls – as well as their parents and teachers – are hesitant to speak out about the problem, let alone bring charges. One reason is the lack of clear guidelines for reporting, dealing with or even defining sexual abuse and harassment. An additional obstacle is the reluctance of schools to suspend or dismiss abusive teachers, given the dwindling numbers of qualified teaching staff as a result of HIV/AIDS and the brain-drain to industrialised countries.

Learning Life Skills

A regional UNICEF study on gender, sexuality and HIV/AIDS, published in 2003, made it clear that boys and girls urgently need to learn respectful ways of dealing with each other on a basis of equality. Both sexes would benefit from participatory life-skills programmes, conducted both in and out of school and supported by appropriate training for teachers and peer facilitators. Such programmes would help reduce violence against women and girls and thus the risk of HIV transmission.

So far, only four out of nine Southern African countries covered in this report have developed fully fledged life-skills programmes. Even where such programmes do exist, curriculum materials fail to deal adequately with gender roles, outreach to out-of-school children is almost non-existent, and few teachers feel properly equipped to teach the subject. Indeed, teachers often tend to reinforce rather than challenge existing gender stereotypes. As one adolescent girl in Botswana recounted, when a female teacher was giving back test papers in which girls had performed better than boys, “she told the boys she was going to beat them because they were not supposed to be led by girls and went ahead and beat them.”

What do we do now?

If we are to keep girls – and particularly orphaned girls – in school, no single step is more important than to hold down the costs of education by subsidising or abolishing school fees and keeping the cost of textbooks and uniforms to a minimum. This will require innovative thinking by governments, and several creative initiatives are already underway. These include efforts in Namibia and Swaziland to provide economic support to schools in communities hardest hit by HIV/AIDS, as well as cash grants to poor families and income-generation opportunities for girls.

At the same time, quality education for girls does not necessarily depend on conventional schooling and rigid curricula.



Giacomo Pirozzi / UNICEF

Julia, 10, participates in a math lesson at a community school run by the Salvation Army in Lusaka, Zambia.

Governments need to examine a variety of flexible learning options such as double-shift systems, multi-grade teaching, distance education and minimum learning packages. In Zambia, for example, the Interactive Radio Initiative (IRI) has proved that solid learning can take place in the absence of a traditional school infrastructure. With little more than their radio sets and community “mentors”, Zambian children in vulnerable communities regularly outperform their peers in conventional schools.

The Mnjolo Community in Malawi offers an encouraging example of what can be accomplished when communities become actively involved in girls' education. With the help of two trained facilitators, routine community gatherings such as markets, storytelling sessions and meetings of parents' and teachers' associations provide opportunities to discuss how factors such as HIV/AIDS, as well as initiation ceremonies and other traditional practices, have led to girls dropping out of school. Through this dialogue, members of the community committed themselves to keeping girls in school, the curriculum was expanded to include life-skills education, and school facilities were improved to provide recreational opportunities for both sexes. As a result, school enrolment increased by about 50 percent and no further drop-outs were recorded.

As we work to eliminate sexual abuse in schools and educate boys and girls in a broad range of social competencies, the key to success will be the ability of governments, schools and communities to work closely together. This kind of collaboration will be essential in developing clear norms and guidelines for preventing, reporting and responding to sexual abuse, violence and harassment in schools – including abuse by teachers. Girls must feel able to speak out about abuse, and communities, schools and justice systems must learn how to listen to their complaints and provide effective remedies. Life-skills education, including a clear focus on gender roles and relations, will likewise depend on active community involvement. While governments must take the lead in expanding and formalising life-skills education and providing gender training for teachers, schools and communities must work to ensure that these programmes reach young men and women who are not enrolled in school.

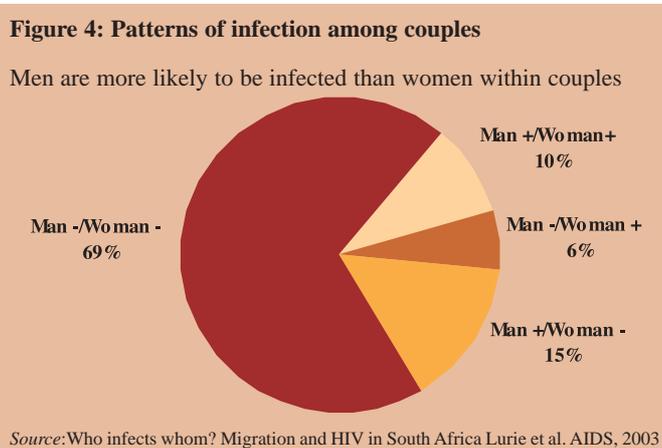
3. “ABC-PLUS” - NEW APPROACHES TO PREVENTION

For many years now, the main message to young Africans seeking to avoid HIV infection has been the “ABC” of prevention – *Abstinence, Being Faithful, and Condom Use*. Public awareness of HIV/AIDS have begun to translate into behaviour change – especially amongst some groups of men. But for women and girls, the messages seem to have been missing the mark. Why should that be? Why are these messages not enough for women?

While all young people in the 15-24 age group are at risk of contracting HIV/AIDS, girls are especially vulnerable. Roughly two-thirds of young people living with the virus or AIDS related illness in Southern Africa are women and girls.

One basic reason for this disparity is biological. One of the main ways in which the HIV virus enters the human body is through its mucous membranes. Girls are at special risk here, since their vaginal membranes are still immature and are easily torn during sexual intercourse. Another increased risk factor is that girls tend to start having sex regularly at a younger age than boys. However, prevailing social norms call for girls to be passive and ignorant of the realities of sex. It is men, they are taught, who dictate the terms of sexual relationships. “They all think that girls are supposed to be their doormat,” said a fifteen-year-old girl in South Africa. “I think boys must be taught to look at girls as people.” Furthermore, in Southern Africa sexual encounters are often forced or coerced, and they are characterised by striking age differences between younger girls and older men. The result is a recipe for disaster.

There is nothing inherently wrong with the “ABC” messages. Yet they do not go far enough. Specifically, the “ABC” approach makes no distinction between the different needs of men and women, and fails to offer African girls real options that are attuned to the reality of their daily lives.



"I DON'T WANT TO DIE BEFORE I'M 110 WITH GREAT GRANDCHILDREN. I DON'T WANT TO DIE BEFORE I TURN 25. I REFUSE TO SIT DOWN AND WATCH MY GENERATION FALL TO PIECES. I AM GOING TO MAKE A DIFFERENCE...WILL YOU?"

RUMBIDZAI GRACE MUSHANGI, 15, ZIMBABWE²



Giacomo Pirezzi/UNICEF

A group of adolescent girls attending a loveLife event in KwaZulu-Natal, South Africa.

Abstinence is unrealistic in an environment in which boys are encouraged to be sexually aggressive and girls are kept in ignorance about their own sexuality. And calls for abstinence are, of course, meaningless when sexual activity is coerced, or when women and girls feel they must resort to sex as a matter of survival.

Being faithful only works if both partners play by the same rules. Yet prevailing norms encourage men to have multiple partners. As one male adolescent in Namibia put it, “You can get famous if you have a lot of girls.” Fidelity will do nothing to protect a girl or woman against HIV/AIDS if her partner is unfaithful; nor will fidelity to an older male who is more likely to be infected (see Figure 4).

Condom use is almost invariably a male decision, and many men remain deeply reluctant to use them. Alternative forms of contraception, meanwhile, which might give greater power to women and girls, are hard to come by. Microbicides are still a distant though foreseeable promise, while female condoms are neither widely available nor easily affordable. Furthermore, although they are controlled by women, their use often calls for the kind of negotiation with a partner and the kind of familiarity with one’s body with which few women feel equipped.

² Posting on UNICEF Voices of Youth website: www.unicef.org/voy/

In order to protect themselves effectively against HIV/AIDS, women and girls will need more than the slogans of ABC. They will need the tools to breach the culture of silence that surrounds issues of sexuality; and they will need the power to resist exploitative, abusive (and often inter-generational) sex.

The Culture of Silence

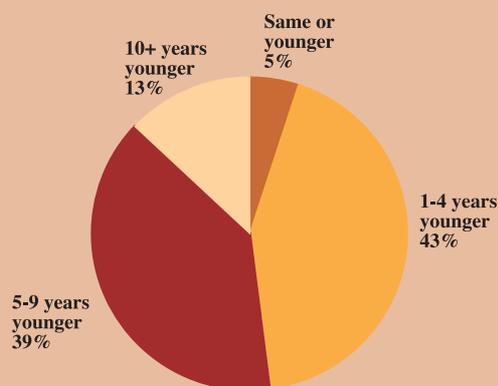
For girls especially, sex remains shrouded in taboos. Parents are reluctant to discuss it with their children, and both boys and girls remain largely ignorant of the real risks of transmission. Despite being surrounded by HIV prevention messages, most young people do not consider themselves personally at risk, and have little idea how their bodies and reproductive systems work. Educational campaigns have made little effort to differentiate between the informational needs of boys and girls, and young women who show that they are knowledgeable about their own sexuality are often stigmatised as “bad girls.”

Older Men, Younger Girls: Exploitative Sex Between Generations

Sex between young women and older men is all too common, and all too widely accepted, in sub-Saharan Africa. The younger the girl, the more dramatic the age difference. In one study in Zimbabwe, for example, two out of every three young women aged 17-24 reported that their most recent sexual partners were more than five years their elder; and more than half of all young Zimbabwean women say that this was the case with their first sexual experience (see Figures 5 and 6).

Figure 5: More than half of all young women have first sex with a man 5 years or older

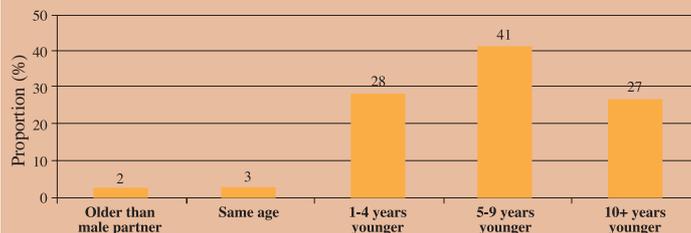
Age-difference (numbers of years older/younger) between female respondent and **first sex partner** for respondents aged 15-29 years, Zimbabwe, 2002



Source: The Zimbabwe Young Adult Survey, 2001-2002.

Figure 6: Young women have partners 5–10 years older than themselves

Age-difference (numbers of years older/younger) between female respondent and **most recent** sexual partner for respondents aged 17-24 years, Manicaland, Zimbabwe, 1998/2000



Source: Sexual mixing patterns and sex-differentials in teenage exposure to HIV infection in rural Zimbabwe, Simon Gregson, Constance A Nyamukapa, Geoffrey P Garnett, Peter R Mason, Tom Zhuwau, Michel Caraël, Stephen K Chandiwana, Roy M Anderson, THE LANCET • Vol 359 • June 1, 2002 • www.thelancet.com

While girls remain woefully ignorant about their own bodies, boys are socialised to think of themselves as the initiators – and often the purchasers – of sex. Driven by poverty and the desire for a better life, many women and girls succumb to the “sugar daddy” syndrome, exchanging sex for money, goods and other basic services – often with men whom they know. “For most people,” said an adolescent girl in Botswana, “the gifts are a form of bribery to have sex with them.” Young people in Zimbabwe cynically refer to the practice as “food for work.”

This intergenerational sex – for which girls are often wrongly blamed – is one of the key drivers of the HIV/AIDS pandemic, exposing young women to an elevated risk of infection. The reason is that men generally become infected later in life than women, usually in their mid-twenties, once they have had regular sexual contact with multiple partners over a prolonged period. The older the man, the higher the rate of infection. Many girls, on the other hand, become infected almost as soon as they become sexually active. A Zambian study noted that eighteen percent of girls tested HIV-positive within a year of losing their virginity.

What do we do now?

Perhaps the most important challenge facing governments in the sub-region is to deepen public awareness of the inappropriate, abusive and often illegal nature of sexual relationships between older men and teenage girls. If the “ABC” approach to prevention is to work, messages and slogans alone will not be sufficient. For these messages to be internalised and acted upon, girls and women will need to have access to a variety of programmes that are rooted

in an understanding of the real problems they experience in the home, the family and the community. The keys here are education and communication. Governments and their partners will need to ensure that those most at risk have access to the factual knowledge, the practical skills, and above all the assertiveness and self-esteem that will enable them to take control of their own lives.

Programmes such as Zimbabwe's Girl Child Network show what is possible. Launched in 1999, the network has over 20,000 members, organized in 150 girls' clubs. In addition, the Chitsotso Girls' Empowerment Village offers a "one-stop shop" for rural girls, providing counselling, medical services, shelter from abuse, information, training in self-help projects, mentoring in leadership, and a "women as role models" museum of achievements. The results are remarkable. The village has enabled two thousand girls to return to school and its economic self-help projects have shielded hundreds more from the dangers of commercial sex work. Two more Empowerment Villages are being set up in other remote parts of the country. Strikingly, the network has been welcomed and supported by Zimbabwean men.

Initiatives like this suggest what can be accomplished if women and girls are given a voice in their own affairs, and encouraged to deal directly with previously taboo subjects such as HIV, sexuality, contraception and gender inequality. Governments and their partners will need to create the widest possible range of "safe spaces" for information and dialogue – reinvigorated health services capable of providing competent, accurate advice on sexuality, reproductive health and HIV prevention; comprehensive life-skills education in schools, taking advantage of high enrolment rates in the region; and youth programmes that encourage gender equality, in which girls feel free to say what they like and what they don't, and young men learn what constitutes appropriate and respectful sexual behaviour.



Giacomo Pirozzi / UNICEF

Two adolescent girls from a junior secondary school record their discussion on HIV/AIDS awareness and prevention in a booth at Radio Botswana, the national radio station, in Gaborone, the capital.

"To change fundamentally how girls and boys learn to relate to each other, and how men treat girls and women, is slow, painstaking work," says former Mozambican Prime Minister Pascoal Mocumbi. "But surely our children's lives are worth the effort."

4. SILENCE AND VIOLENCE

In addition to the culture of silence surrounding sexuality, and the prevalence of abusive intergenerational sex, a third key factor exposing women and girls to a higher risk of HIV infection is violence within relationships. Violence against women in Southern Africa is deeply embedded in the history of the sub-region. It is rooted in poverty and political instability, in the legacy of civil wars, apartheid and indigenous patriarchy. Rape and sexual violence are not only widespread, but widely accepted and endorsed, with little recourse available for the victims.

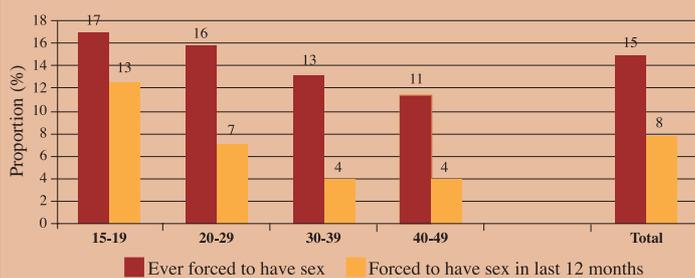
We know that violence and HIV are mutually reinforcing. Violence can lead to infection either directly through the act of rape, or indirectly by predisposing women to risk-taking behaviour later in life. At the same time, there is growing evidence that HIV/AIDS can also be a precursor to violence as women face retribution for disclosing the fact that they are HIV-positive. In none of these cases do women have the kind of support services they so urgently require.

Violence Against Girls

Teenage girls and young women are at special risk of rape and violence, which often accompanies their earliest sexual experiences. In a study in KwaZulu Natal in South Africa, for instance, more than a third of girls aged 15-19 reported that they had lost their virginity as the result of force, coercion or trickery. One in eight teenage girls in a recent Zambian study said they had experienced forced intercourse within the previous year. (see Figure 7) Girls are often held responsible for the violence they suffer – blamed for dressing provocatively or for inviting rape by being too “modern” in their demeanor.

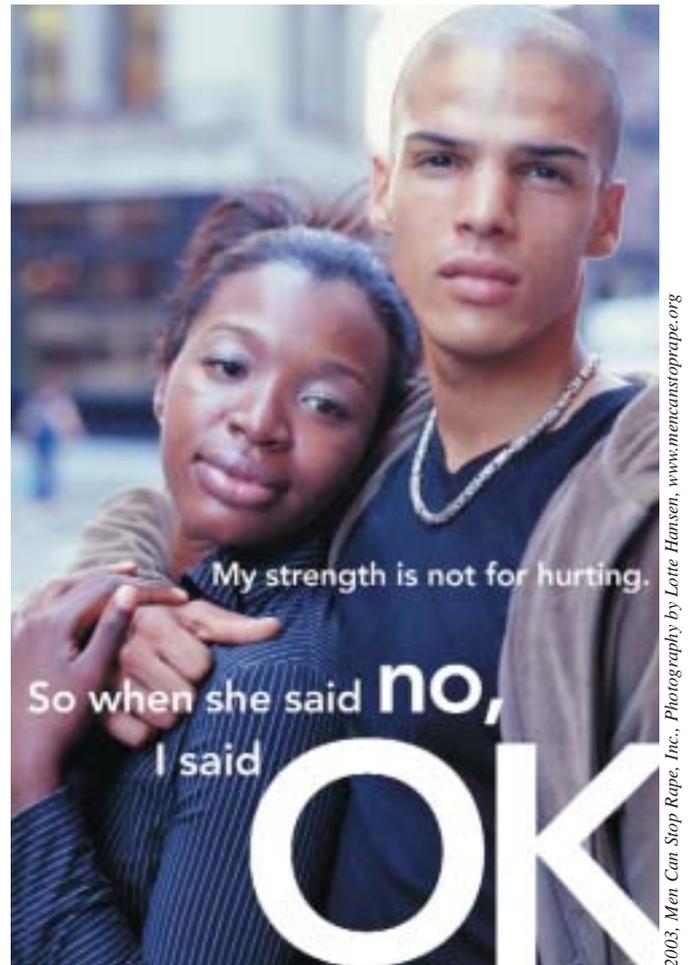
Figure 7: One in eight teenage girls report having been forced to have sex

Percentage of women who have ever been forced by a man to have sexual intercourse, and percentage who were forced to have intercourse in the past 12 months, by age, Zambia 2001-2002



THE NEED FOR ATTITUDE CHANGE:
"WOMEN CAN LEAD A HEALTHY LIFE
IF THEY RECOGNISE THAT THIS IS A
MAN'S WORLD AND THIS CANNOT BE
CHANGED. SO THEY SHOULD STOP
BEING FREEDOM FIGHTERS"

POLICEMAN, URBAN LOWLANDS OF LESOTHO³



The Strength Media Campaign, launched by Men Can Stop Rape in 2001 and 2004, is a landmark educational effort that seeks to prevent rape and other forms of dating violence by focusing on the message that men can be strong without being violent.

Marital Rape

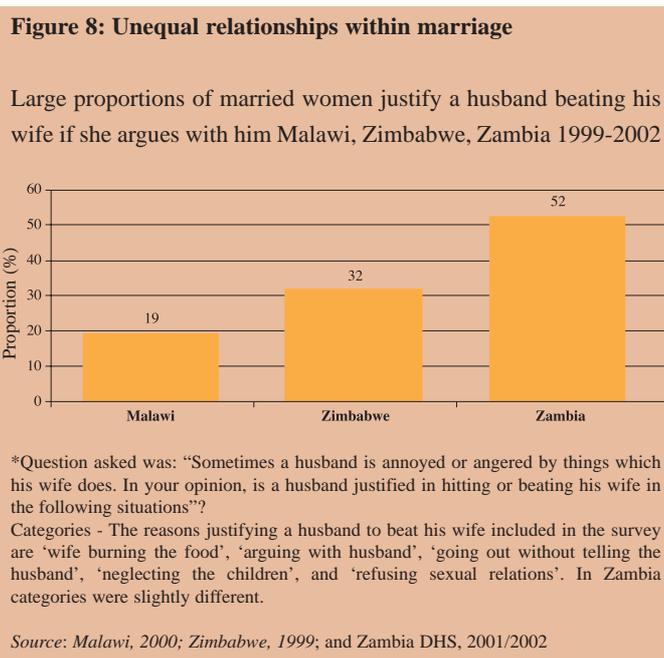
One common misconception is that rapists are usually strangers to their victims. In fact, rape by a spouse, intimate partner or long-time acquaintance is much more the norm, with the abuse often continuing over a prolonged period. Marital rape is disturbingly common throughout Southern Africa, yet despite the efforts of women's groups, judicial and police authorities are still reluctant

³ Ministry of Health and Social Welfare/WHO, "Safe Motherhood Initiative Health Survey: Focus Group Discussions." April, 1995

to consider it a crime. Judges in Botswana and Malawi, for example, have made judgements declaring that consent to sex is inherent in marriage. In other words - husbands cannot rape their wives. Even where marital rape is against the law, as in South Africa, police attitudes can sometimes act as a bar to justice. As one South African woman told a parliamentary hearing, “What must we do? Go to the police? Even if you are raped by a stranger they don’t believe you, and now you must tell them that your husband is raping you?... You can have scars on your face... and police still send you home to ‘sort it out with him.’”

Domestic Violence

Violence by an intimate partner is endemic in Southern Africa. In Harare, Zimbabwe, for example, domestic violence accounts for more than 60 percent of murder cases coming before the courts. A study of three South African provinces revealed that between 19 and 28 percent of women had suffered domestic physical abuse, while a recent study in Namibia by the World Health Organisation (WHO) found that one in five women had experienced physical or sexual abuse during the preceding year; the majority had not sought help. Abuse is so routine that women often come to regard beatings as an expected part of their daily lives. Women are widely blamed for provoking this violence, and they are also held responsible for ending it. “Men see beating as a solution to most problems in the family,” remarked one woman during a WHO study in Lesotho. “The woman is sometimes at fault and the husband is forced to beat her,” commented another. In Malawi, Zambia and Zimbabwe, large numbers of women agreed that a husband was justified in beating his wife if she argued with him, went out without his consent, neglected the children, burned the food, or refused to have sex. (see Figure 8)



Lack of Recourse

Given the scale and widespread acceptance of sexual and domestic violence, it is hardly surprising that women are reluctant to report abuse to the authorities. Even where laws against sexual and domestic violence are on the books, women often remain ignorant of their legal rights. Police officers, prosecutors, magistrates, judges and other judicial officials are rarely given the training they need to handle domestic violence cases with sensitivity. Even when perpetrators are brought to court, convictions are rare and sentences usually light. Pessimistic about judicial remedies, worried about reprisals, and lacking ready access to shelters and other support mechanisms, many women feel they have no option but to remain imprisoned in abusive relationships. In this kind of environment, the close ties between violence and HIV are very clear – fearful of provoking further abuse from violent partners, women feel even less able to negotiate safe sex or demand fidelity.

Violence and HIV

Violent or forced sex obviously increases the risk of HIV transmission. According to the WHO, “in forced vaginal penetration, abrasions and cuts commonly occur, thus facilitating the entry of the virus – when it is present – through the vaginal mucosa.” The risk can be diminished if rape victims have access to “post-exposure HIV prophylaxis” (PEP), which is becoming available on a limited basis in several Southern African countries. But women are often unaware of PEP, service providers frequently lack the training or authorisation to dispense it, and girls who are legal minors may be barred from obtaining it.

Even where sexual assault does not result directly in HIV transmission, it is known to lead to high-risk sexual behaviours in later life. U.S. studies have shown a direct correlation between childhood sexual abuse and, for example: early initiation of sexual activity; numbers of sexual partners; engaging in high-risk sexual acts; sexually transmitted diseases; and prostitution. Given the incidence of sexual violence in Southern Africa, the implications are devastating. Throughout the sub-region, the evidence suggests that abused girls are much more likely to engage in high-risk sex, crying out for help rather than the blame they often encounter.

While violence can lead to HIV infection, the reverse may also be true. Given their access to ante-natal services, women are often the first to be tested for HIV, and as a consequence are routinely blamed for introducing the disease into the household or community – even though their husbands or partners may have been the true source of infection. “I might transmit the disease to my wife then tell my wife to go for an AIDS checkup,” said one man from rural Zambia.

“If she is found positive, I blame it on her and tell the whole community that she has infected me.” Many Southern African NGOs report that this kind of stigma is often a prelude to violence, with women who disclose their HIV status being targeted for abuse and even, in some notorious cases, killed.

What do we do now?

Across Southern Africa, there is a groundswell of public anger as the facts about sexual violence against young girls become more widely known. In several countries, effective new grassroots initiatives are beginning to provide the kind of services and support structures that are so badly needed, offering shelter and counselling to the survivors of violence and removing the barriers that prevent women and girls from accessing the judicial and health-care systems. The challenge before us is to identify the best of these initiatives and ensure that our resources are used to expand and multiply similar efforts throughout the sub-region.

In all countries that have enacted laws against gender-based violence, there is an increase in the reporting of rape and sexual assault. Several countries now have specialised police units dealing with domestic violence and the sexual abuse of women and children. Increasingly, these units offer counselling and either access or referrals to emergency health services. Through the work of Women and Law in Southern Africa (WLSA), whose Mozambique chapter has produced a valuable report on gender-based violence, we have acquired critical new insights into the

specific skills required by police and law enforcement officers, teachers, health care workers and others involved in responding to gender-based violence, and this data now needs to be translated into more effective training programmes.

There is still a critical need for shelters or safe havens where abused women and girls can access legal services and health care. The Kagisano Women’s Shelter Project in Gaborone, Botswana, provides temporary shelter, counselling and round-the-clock support to survivors of domestic violence, while Women Against Rape (WAR) – located a thousand miles away in Maun – offers training in schools on violence, HIV/AIDS and human rights, and works at the community level to help victims of violence to gain legal redress. The South African government, working in partnership with NGOs and women’s groups, has established over 90 “one-stop” facilities for survivors of domestic violence and sexual assault. These one-stop centres offer access at a single site to police, social workers, counselling services and health workers dispensing PEP. These efforts are now being emulated in Botswana, Namibia, Zambia and other Southern African countries.

Encouragingly, a growing number of men are also joining the struggle against sexual violence. The South African organisation Men for Change (MFC) has carried out training sessions not only within South Africa but in Namibia and Zimbabwe, encouraging men to become directly involved in ending gender-based violence. MFC’s workshops have also offered counselling, support services and rehabilitation for perpetrators of sexual violence.

5. “WOMEN’S WORK” - CARING FOR THOSE WITH HIV/AIDS

From earliest childhood, children in Southern Africa are brought up to see a sharp distinction between “men’s work” and “women’s work.” The former is seen as work outside the home for payment. The latter revolves mainly around the household, and involves taking care of children, cooking, cleaning and other domestic chores, as well as subsistence farming. Women are more likely to take on additional roles in the community, often voluntarily and in their “free time”. Boys are particularly invested in these stereotypes, and few would admit to doing work that might appear “girlish”.

Despite the general perception that men are better suited than women for hard work, the fact is that women work significantly longer hours than men, and in ways that are often more physically demanding, when both household work and income-generating activities are taken into account. The inescapable reality is that “men’s work” is valued while “women’s work” – though often more difficult and time-consuming – is not.

HIV/AIDS and Women’s Labour

The HIV/AIDS crisis has greatly increased the responsibilities of women and girls, both within the home and in the wider community. One recent survey of households in South Africa revealed that two-thirds of caregivers were female, with almost a quarter of them over the age of 60. Women continue to play this role even if they are the ones with the disease. “What happens,” says one elderly woman in Lesotho, “is that the woman will just keep working, because no one else does chores and sometimes for the sake of the children the woman will do the housework despite her illness.” Men do become involved in home and community-based care when they are actively recruited, or when they receive training and remuneration. But their role is often restricted to tasks that require physical strength.

Care is often narrowly defined as attending to the sick and dying. In fact, it embraces a wide range of other responsibilities, including emotional and mental care and care for children who have lost one or both parents to AIDS. The work is physically and emotionally exhausting, and without the medicines they need to alleviate the suffering that surrounds them, caregivers often experience a feeling of helplessness.

Caregivers fall into three broad categories: home carers, professional health-care workers and community volunteers.

“OUR GRANDMOTHER IS SO WONDERFUL. SHE HELPS US IN SO MANY WAYS. SHE FEEDS US, DRESSES US AND BRINGS US UP PROPERLY. WHEN WE SEE HER, WE SEE OUR MOTHER...WE ARE SO GRATEFUL SHE IS STILL WITH US.”

CATHERINE, 15, THE ELDEST OF EIGHT GRANDCHILDREN BEING CARED FOR BY TIER 80-YEAR OLD GRANDMOTHER IRENE IN MALAWI⁴

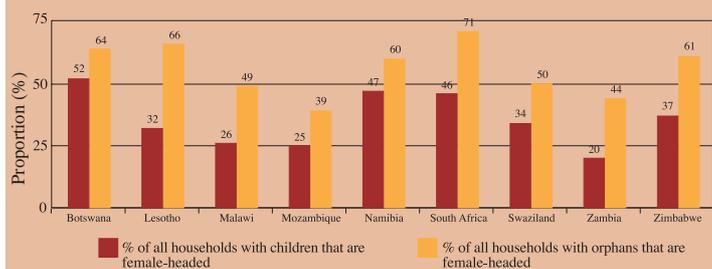


In Kuanda village, in the Ekwendeni district of northern Malawi, 65-year-old Maritas Shaba - a bowl of mangos balanced on her head - stands in front of her small hut with six of her nine grandchildren. Maritas has become the children’s guardian, since the death of both their parents from AIDS.

Home Carers: Women usually bear the main burden of caring for sick family members in the home, cooking, cleaning and arranging for hospital and clinical care. Women with AIDS are commonly sent back to their natal families to be looked after by female relatives. Yet when a man falls sick, his wife or a female relative is normally expected to take care of him. Even in cases where their mother has died, orphans are more likely to end up in a female- than a male-headed household. And throughout the sub-region, female-headed households are caring on average for a greater number of orphaned children. As the number of deaths from AIDS grows, these women are increasingly older, with grandmothers now caring for far more orphans than they did a decade ago. In Botswana, for example, grandmothers now care for more than half of all orphans.

⁴ HelpaGe International, International AIDS Alliance, Forgotten Families: Older People as Care-Givers of Orphans and Vulnerable Children, 2003

Figure 9: Women are more likely to take responsibility for orphans



Source: Africa's Orphaned Generations, UNICEF/UNAIDS, 2003

Health-Care Professionals: The AIDS crisis is taking a severe toll on nurses and other health-care professionals, the majority of whom are women. Many health-care workers express despair that hospital wards are becoming little more than hospices for the terminally ill. One recent study in South Africa showed that 46 percent of patients in public hospitals are HIV-positive and that AIDS patients have started “crowding out” others. At the same time, fewer nurses are available to deal with these heavier caseloads, as many leave the region for higher-paying and less stressful jobs abroad.

Community Volunteers: In both urban and rural areas, community-based care falls squarely on the shoulders of volunteers, the vast majority of whom are women. Yet these care-givers, without whom many HIV/AIDS-related programmes would simply collapse, receive scant respect or recognition. Often every bit as poor as the people for whom they are caring, they commonly experience exploitation and burn-out, and even face discrimination as “just volunteers” within NGOs. Hitherto, these women volunteers have been taken for granted as an infinite free resource, but as the death toll from AIDS continues to mount, this situation is becoming untenable.

The Economic Impact of AIDS Care

In addition to the severe emotional stress of care-giving, the hidden economic impact on families and communities has been devastating. According to one South African study, the primary caregiver in almost half of all households had been forced to take time off from work or school. Caring for those with HIV/AIDS has eaten up as much as 60 percent of the time that women and girls formerly devoted to other housework or gardening, undermining the ability of poor households to grow food for consumption or sale.

Communities have devised a variety of income-generating activities to mitigate the economic impact of the pandemic. Yet while many agencies now specialise in micro-credit and the development of entrepreneurial skills, few of the benefits have yet filtered down to communities affected by HIV/AIDS. The National Zambian People's Positive Association (NZP+) is typical of many community-based initiatives struggling with badly planned, small-



Cindy Andrew/UNICEF

A girl and her baby, Lilongwe, Malawi.

scale projects that do little to alleviate poverty in a sustainable way. A woman activist with NZP+ complains that the organisation lacks the resources that would allow it to market the AIDS-related products it makes – red ribbons and doormats – as a way of generating income. “Money is coming into the country because of HIV,” she says, “but why is this money not coming directly to us? Look at the number of children we take care of.”

What Do We Do Now?

In the fight against HIV/AIDS, volunteer labour can no longer be taken for granted. A Volunteer Charter is urgently needed, spelling out clearly that the women and men who care for those living with HIV/AIDS deserve not only respect, but also standardised working hours, remuneration, psycho-social support and other tangible protections. Women caring for the sick in their homes and communities should be given the supplies they need to cope effectively – gloves, bleach, food etc. – as already happens in countries like Botswana, Namibia, South Africa and Swaziland. To the widest extent possible, they should also benefit from the kind of pensions, child-support grants and other social protection measures that are already available in some countries. Where such resources exist, they should be readily accessible to those who need them – especially the grandmothers and older women who make up an ever-larger proportion of caregivers but may have difficulty dealing with bureaucratic red tape.

It is impossible to overstate the stress, grief and trauma of caring for the sick and dying. Both at the community level and among health-care professionals, care-givers themselves require a degree of psycho-social support that is not presently available. This may take the form of symbolic gestures, such as the October 2003 vigil at Baragwanath Hospital in Soweto, South Africa, which brought together family members and caregivers who had experienced a death in the previous year. Or it may take a more structured form,

such as the counselling and support-group activities planned by the Nurses' Association of Swaziland under the title "Caring for Carers."

Women and girls affected by HIV/AIDS need access to the kind of sustainable income-generating activities that will allow them to deal with the impact of the disease. It is important to apply the lessons learned from local projects such as those run by the Swaziland Positive Living for Life Organisation (SWAPOL) or the Integrated Livelihood initiatives of Ndamambe village in Malawi.

Both these programmes have succeeded in integrating economic production, effective marketing and reinvestment in the community. Members of SWAPOL have developed local markets for their cash crops, vegetable seedlings and poultry, as well as for the school uniforms and tracksuits they sew. They also sell their maize to the national maize marketing association. Half their profits are ploughed back into the project, with the remainder divided equally between SWAPOL members and an orphans' trust fund they have established. Ndamawambe village projects, meanwhile, include bee-keeping, bakery, fish-farming, mushroom-growing, cooking oil refining, juice extraction and livestock production. The village, which includes 155 orphans, has also trained volunteer groups to provide HIV/AIDS counselling, promote voluntary counselling and testing services (VCT), and support home-based care. For initiatives like this to take root more widely, they will need external support and resources.

The burden of caring for the sick, the dying and the orphaned needs to be shared more equitably among all members of the community. This means exploring innovative solutions such as community



Giacomo Pirozzi / UNICEF

An adolescent Zimbabwean girl, Febbie Yaso, 15, does schoolwork at the home of her neighbour, Barbara, in Epworth, an urban area 20 km southwest of Harare, the capital. Febbie, whose parents died of AIDS, lives alone in her family's house after being abandoned by her older brother. Barbara, who has five children of her own and also cares for a nephew orphaned by AIDS, cares for Febbie, including paying her school fees.

gardens, communal food preparation and group childcare. Above all, it must involve a sustained effort to recruit men into home-based and community care programmes. Men will need active support if they are to play the role of primary care-givers in households affected by HIV/AIDS, and boys must be socialised from an early age to accept that caring for the sick is not merely "woman's work."

6. PROPERTY AND INHERITANCE RIGHTS

Joyce Giya is a mother of three in Malawi, whose husband died of AIDS. “We live here [in a one-room shack] now because of my husband’s death,” she told a reporter. “His parents no longer consider me related to them, and two years ago they forced me from the house that my husband and I built.”

The plight of women like Joyce Giwa is echoed throughout the sub-region. Without the enforceable right to own or inherit land and property, women and girls all too often face dispossession and destitution after the death of a husband, partner or parent, while poverty and economic dependence leave them exposed to increased sexual exploitation and violence. As the death toll from AIDS mounts and poverty deepens, dispossession is on the rise in both rural and urban areas. It may even occur before a woman is widowed: researchers have reported examples of women being thrown out of their homes after disclosing their HIV status to a spouse.

Law and Custom

Most Southern African cultures are patrilineal; when a woman marries according to customary law, she joins her husband’s clan and property devolves along the male line. Women access property through men – their fathers, husbands, brothers, sons or male cousins. Before Southern Africa was colonised, land was controlled by (primarily male) chiefs for the benefit of the entire community – including women. Colonialism brought about two legal changes that profoundly affected women. First, English law superimposed the concept of private property on these older traditions. As we are now witnessing, individual property ownership carries none of the obligations to the broader community that went with the more traditional forms of communal land use and distribution.

Secondly, colonialism introduced marriage as a legal contract. This new contract discriminated against women in part because it was based on a legal tradition of male wage labour and property ownership. Married women, therefore, could not own or inherit property. This practice continues across the sub-region, either in law or in practice, despite the fact that it contravenes CEDAW. This is because most Southern African countries operate a dual legal system, with civil law and customary law coexisting. However, because customary law became more rigid as a result of colonialism, it has been necessary for countries with dual systems to prioritise women’s rights over traditional customs and practices.

"WE LIVE HERE IN A ONE-ROOM SHACK NOW BECAUSE OF MY HUSBAND'S DEATH. HIS PARENTS NO LONGER CONSIDER ME RELATED TO THEM, AND TWO YEARS AGO THEY FORCED ME FROM THE HOUSE THAT MY HUSBAND AND I BUILT."

JOYCE GIYA, MOTHER OF THREE, WHOSE HUSBAND DIED OF AIDS, MALAWI⁵



City Stabbs

Without the enforceable right to own or inherit land and property, women and girls all too often face dispossession and destitution after the death of a husband, partner or parent, while poverty and economic dependence leave them exposed to increased sexual exploitation and violence.

Yet this has not always been the case. In the case of *Magaya v Magaya*, the Supreme Court of Zimbabwe decided that in spite of Zimbabwe’s recognition of women’s rights to own and inherit land in civil law, Venia Magaya could not inherit the estate that had belonged to her deceased father. The judges chose to defer to customary law, under which women cannot inherit land. “Women,” they wrote, “should never be considered adults within the family, but only as a junior male or teenager.”

Although such practices are on the wane, some communities still engage in harmful traditions such as sexual “cleansing” and “widow inheritance.” The first of these demands that a woman have sexual intercourse with a male relative of her deceased husband, as a way of releasing evil spirits left behind after his death. Meanwhile, because a woman joins her husband’s clan upon marriage, the tradition of “widow inheritance” requires her, after his death, to marry one of his male relatives in order to retain her link with the clan and her claim to any property. Traditionally this

5 PBS Online Newshour, AIDS in Malawi, 26 August 2002: www.pbs.org/newshour/bb/africa/july-dec-2/malawi_8-26.html

implied that the man was responsible for ensuring the well-being of the woman and her children; nowadays, to the extent the practice continues, it mainly appears to be a way of gaining possession of the dead man's property.

Lack of Recourse

Although legal protections for women do exist in the great majority of Southern African countries, a variety of obstacles stand in the way of any woman attempting to assert her rights to property or inheritance. Fear of violent reprisals, and accusations of "greed" or of being a "traitor" to one's culture, are enough to keep many women quiet. Those who do try to fight back must often confront sluggish bureaucracies and official indifference. Navigating complex systems of land administration requires time, literacy, patience, knowledge of one's rights, and the wherewithal to travel to government offices which are often located far from home. Police are generally reluctant to intervene in cases of dispossession or property disputes, while many judicial officials are either hostile, indifferent or insensitive to women's rights, or lack the relevant training.

A few determined organisations are attempting to provide women with legal education and advice about property rights. But their work is hampered by restrictive legislation, a lack of funding and external support, and a shortage of trained paralegal staff. Some community-based projects, such as Justice for Widows and Orphans in Zambia, which works closely with police and traditional leaders, have encouraged both men and women to write wills that protect the rights of their spouses and children. But such activities are sometimes perceived as being "against African culture," which regards any talk of the impending death of a loved one as "calling death to the house." Written wills may also clash with complex traditional rules about property ownership and are hard to reconcile with the realities of polygamy. As one Malawian woman put it, "you can't split a bicycle three ways."

What Do We Do Now?

In the context of HIV/AIDS, the rights of women and girls to own and inherit property, regardless of their marital status, have become a matter of real urgency. Denial of these rights is a violation of CEDAW, which has been ratified by every Southern African country with the exception of Swaziland. It is therefore critically important for countries in the sub-region to enact laws protecting

women's rights to property, and to protect women who seek to assert those rights through the legal system.

Those are long-term goals, of course, and comprehensive legal reform will take years. But as the countries of Southern Africa embark on the process, there are many steps that can and should be taken immediately to start breaking down the barriers that exist to women's property rights. These steps include, for example:

- measures by local governments to protect women and girls who have been dispossessed, restore property that has been taken from them, and train paralegals to provide advice and assistance;
- overhauling and decentralizing cumbersome land administration systems to make them more accessible to women and the rural poor;
- working with traditional leaders to resolve discrepancies between women's property rights and the discriminatory provisions of customary law;
- training police and judicial officials to respect and uphold laws in situations where women have been victimised; and
- incorporating materials on property and inheritance rights and succession planning into a variety of settings such as secondary school curricula, marriage preparation, and voluntary testing and counselling programmes.

Initiatives such as these should go hand-in-hand with increased funding for grassroots organisations working to uphold women's property and inheritance rights. Namibia's Legal Assistance Center (LAC), for example, has conducted successful workshops on property grabbing for communities, NGOs, social workers, traditional leaders and women victims, and has developed training materials on will-writing.

Progress on sensitive issues such as these will depend on traditional leaders becoming full partners in the struggle against HIV/AIDS. As keepers of the traditions and laws of African cultures, these authorities have a critical role to play in mediating disputes within their communities and supporting women in their efforts to recover property. Traditional leaders are ideally placed to ensure that the protective features of customary law are used to complement common law and protect women's rights. For example, after extensive discussions, Ondonga traditional leaders in Namibia recently amended their customary law to provide that women should remain in possession of land after the death of their husbands.

7. ACCESS TO CARE AND TREATMENT

Every person living with HIV/AIDS has the right to medical care and treatment, and the international community has a clear obligation to make treatment affordable for governments in developing countries. Pilot programmes such as that run by *Médecins sans Frontières* (MSF) in Khayelitsha, South Africa, have demonstrated convincingly that cost-effective treatments are possible in resource-poor settings. As a result, with increased international funding, more Southern African countries are following Botswana's lead and rolling out anti-retroviral treatment through their national health systems.

In most parts of the world, men enjoy greater access than women to HIV/AIDS care and treatment. Higher rates of employment give men more opportunities to obtain private medical insurance, and they are usually better able to pay for treatment. Men are also more likely to take part in drug trials, since researchers are reluctant to expose women to potential health risks in the event of pregnancy. In Africa, however, while overall treatment rates remain very low for both sexes, women tend to have more access than men to Highly Active Anti-Retroviral Therapy (HAART). The reason is that they have more frequent contact with public health institutions, with most referrals to HIV/AIDS treatment coming through ante-natal services.

Short-term AZT or single doses of Nevirapine are also being made available in many Southern African countries to prevent mother-to-child transmission of HIV (PMTCT). However, these do nothing to meet women's long-term needs, and it is still not clear whether they may compromise their future treatment options by increasing drug resistance.

Barriers to Treatment

Many women still face significant gender-based barriers to treatment, including stigma, discrimination and even violence. The stigma attached to HIV/AIDS affects men and women differently. While both sexes are likely to face discrimination because they are living with HIV/AIDS, women are more likely to be held responsible for introducing it into their families and communities. According to the South African chapter of the International Community of Women Living with HIV/AIDS,

We are often blamed for bringing HIV into the marriage or home, or for infecting our children. There are perceptions in society that see women as responsible for HIV – this is because most of the statistics in the media are of women.

"AFTER (MY CHILD) UNATHI DIED I TRIED TO SEE IF I COULD TELL MY BOYFRIEND ABOUT THE HIV. HE SAID HE WOULD TAKE A GUN AND SHOOT ME AND HIMSELF IF WE WERE HIV POSITIVE, SO I DECIDED NOT TO TELL HIM."

THANDISWA YIBATHA, HIV POSITIVE WOMAN ENROLLED IN MEDICINS SANS FRONTIERS TREATMENT PROGRAMME⁶



Giacomo Procci / UNICEF

A woman health worker, Violet Bvule, gives information on the antiretroviral drugs that she is providing, and instructions on how to take them, to a young woman who is pregnant and has just been advised that she is HIV positive, in the maternity ward at Epworth Polyclinic, in Epworth, an urban area 20 km south-west of Harare, the capital of Zimbabwe.

Girls under the age of eighteen, who account for a large proportion of all pregnancies in Southern Africa, are likely to face additional barriers, since they may be legally barred from giving their consent to testing and treatment – even treatment that is aimed at preventing mother-to-child transmission. This can be a particular problem for orphans, who may have neither legal guardians nor identification documents.

As we have seen, many women fear that stigma will lead to violence once their HIV status is disclosed, and so avoid being tested or seeking treatment. According to Thandiswa Yibatha, who is enrolled in the MSF's Khayelitsha programme,

After [my child] Unathi died, I tried to see if I could tell my boyfriend about the HIV. He said he would take a gun and shoot me and himself if we were HIV-positive, so I decided not to tell him.

6 Mail & Guardian (Johannesburg) - February 15, 2002 on <http://www.aegis.com/news/dmg/2002/MG020221.html>

Because of her partner's inability to face the truth, Thandiswa put off getting treatment for herself – and another of her children died of AIDS.

The Need for Testing

The reality is that most people living with HIV are unaware of the fact that they have the virus. Most women who find out that they are HIV-positive do so as a result of being tested at an antenatal clinic. But voluntary counselling and testing services (VCT), which provide the main entry point for treatment, are usually not available to girls and women unless they are seeking reproductive health care. For men, access to VCT is especially problematic. Since they rarely seek help for any kind of medical problems, men are particularly unlikely to seek the benefits of HIV drugs while their distribution is restricted to reproductive health facilities. Currently many Southern African countries face an acute shortage of VCT facilities and trained counsellors, and this deficit will need to be addressed if HIV medication is to reach the entire population in an equitable way.

Comprehensive Health Care

Treatment for opportunistic infections, as well as reproductive health and family-planning services, should be part of a comprehensive HIV/AIDS-related health-care package. Women and men with HIV-related diseases often lack timely access to the treatment they need, whether or not they eventually benefit from HAART. While some opportunistic infections could be treated relatively cheaply at home, palliative care remains almost non-existent, placing an additional burden on the women who provide the bulk of home-care. As the epidemic matures, and the older female caregivers begin to die, the survivors will be left to fend for themselves.

What Do We Do Now?

A variety of new initiatives offer the hope of expanded access to HIV/AIDS testing and treatment in Southern Africa. As these programmes grow, governments and international donors will need to strengthen the underlying capacity of each country's health-care delivery systems and ensure that the new services are guided by the principles of gender equity.

One breakthrough over the last year was the announcement by the World Health Organisation (WHO) of its "3 x 5" initiative, which aims to provide access to treatment for at least three million people living with HIV/AIDS by 2005, based on the principles of "urgency, equity and sustainability." The WHO initiative aims to use multiple entry points for treatment, to ensure that it is as widely available as possible and not restricted to women who come into contact with antenatal clinics. This should also have a positive impact on men's access to treatment.



Louise Gutbb

A Zambian sister at a prevention of mother-to-child HIV transmission clinic checks the foetal heartbeat of a pregnant women with HIV.

Increased involvement of male partners is also an important feature of the MTCT-Plus Initiative, launched by the Mailman School of Public Health at New York's Columbia University in response to the shortcomings of traditional PMTCT strategies. Through MTCT-Plus programmes in Mozambique, South Africa and Zambia, not only women but their partners and children receive ongoing treatment, education, counselling and psycho-social support. One MTCT-Plus site, the Chelstone Clinic in Zambia, is using innovative strategies with male partners, reaching out to them at drinking places and sports events and on weekends, to persuade them to make fuller use of the treatment services that are available.

Initiatives such as these will need to be closely coordinated with national anti-retroviral (ARV) programmes and with expanded voluntary counselling and testing (VCT) services, as these are rolled out in a number of Southern African countries. Both ARV and VCT programmes will need a persuasive educational component, strong enough to overcome the stigma that prevents many sick people from seeking treatment. The success of these programmes is also directly related to the underlying strength of a country's health-care infrastructure. As rollout proceeds, this infrastructure must be steadily bolstered through investments in laboratory services, efficient systems for drug procurement, management, monitoring and accounting, and training for health-care workers. One important aspect of this training will be to give VCT counsellors clear guidance on gender-based violence, partner notification and confidentiality. As VCT opportunities expand, every effort must be made to ensure that girls under 18, including orphans, are not excluded from the benefits of voluntary testing, treatment and counselling.

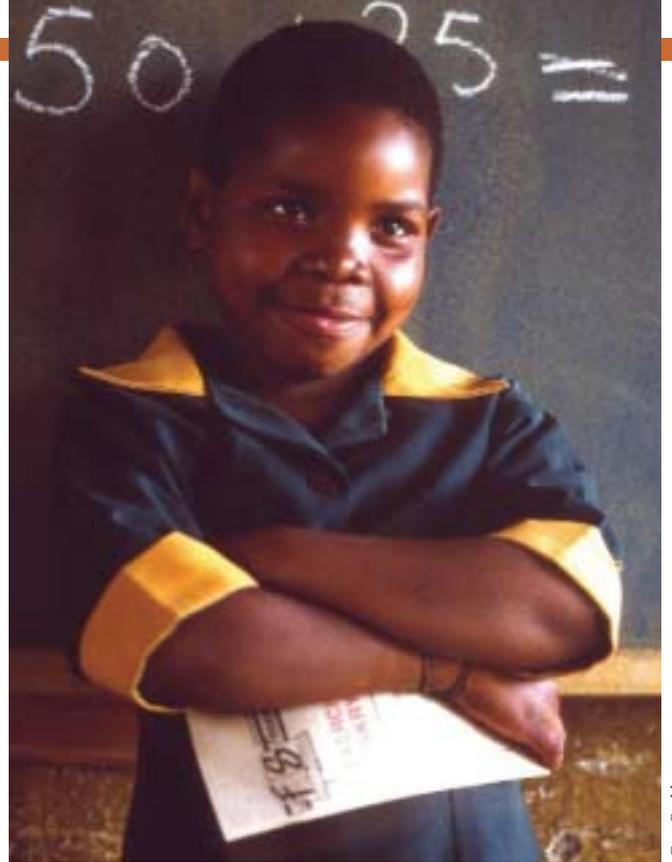
8. CONCLUSION

HIV/AIDS and gender inequality are twin and intersecting challenges that confront this region. Yet this report has demonstrated that there are tangible ways in which development actors can work to expand women and girls' possibilities and choices.

Firstly, there is need for public engagement around shifting the social norms and values that undermine women's rights. Because gender inequality is supported in attitudes and behaviours and is expressed in the informal spaces in which people live their lives, the media has a critical role to play in this regard.

Simultaneously, improving the self-esteem, confidence, respect and self-awareness of boys and girls is essential. Yet self-esteem and self-respect mean nothing if laws and policies do not allow women to access opportunities. Focused efforts to create an enabling environment for women's rights are more important now than they have ever been.

Lastly, and most importantly, as this report has pointed out, Southern African states must expand and strengthen existing health and education institutions in order to reach women and



girls who are ordinarily ignored. States – in partnership with women's groups, associations of people living with HIV/AIDS and other civil society actors – can provide their citizens with the services and protections necessary to experience longer, healthier and more equal lives.

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“More households here are headed by women than in any other part of sub-Saharan Africa. Altogether, more than thirty-four percent of households with children are female-headed – almost double the rate in West and Central Africa. The proportions are especially high in Botswana (52 percent), Namibia (47%) and South Africa (46%).”

Source: *UNAIDS/UNICEF Africa's Orphaned Generations, New York/Geneva, 2003.*

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“In Lesotho, for example, recent statistics show that HIV/AIDS and poverty are responsible for a 25% drop in female enrolment over the last decade, with orphans dropping out at an even more dramatic rate.”

Source: *UNICEF Lesotho Annual Report, 2003*

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For more on the Mjolo Community Dialogues, please see the Mozambique Report of the Secretary General's Task Force on Women and Girls in Southern Africa.

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“Many girls on the other hand, become HIV positive almost as soon as they become sexually active. A Zambian study noted that eighteen percent of girls tested HIV positive within a year of losing their virginity.”

Source: *Buve et al, 2001, cited in "The Epidemiology of HIV at the*

Start of the 21st Century: Reviewing the Evidence. Pisani, E. UNICEF, 2003

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For more on the Zimbabwean Girls Child Network, please see the Zimbabwe Report of the Secretary General's Task Force on Women and Girls in Southern Africa.

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“One recent survey of households in South Africa revealed that two thirds of caregivers were female, with almost a quarter of them over the age of 60.”

Source: *Steinberg M. et al Hitting Home: How households Cope with the Impact of the HIV/AIDS Epidemic - A Survey of Households Affected by HIV/AIDS in South Africa. Henry J. Kaiser Family Foundation, October 2002.*

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“One recent study in South Africa showed that 46% of patients in public hospitals are HIV positive and that AIDS patients have started ‘crowding out’ others.”

Source: *The Impact of HIV/AIDS on the Health Sector. Human Sciences Research Council, Medical University of South Africa (Medunsa), 2004-06-28*

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Caring for those with HIV/AIDS has eaten up as much as 60 percent of the time that women and girls formerly devoted to other housework...”

Source: *Steinberg et al. Op cit.*

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